TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health

Respondent Name
Liberty Mutual Insurance Company

MFDR Tracking Number
M4-16-0825-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Prior Authorization was obtained for all the services we provided, which were medically necessary in aiding the patient recovery for the work related compensable injury…"

Amount in Dispute: $216.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There were two requests for preauthorization of psych services. The initial authorization (#13022 on 8/21/14) gave approval for 6 visits billed with code 90837. The second preauthorization (#178233 on 11/10/2014) approved 6 additional visits but these were to be billed with code 90834."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2 – 11, 2014	Psychotherapy (90837)	$216.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 defines the services that require preauthorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.

Issues

1. Is preauthorization required for the disputed services?
2. Was preauthorization obtained for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The dispute involves procedure code 90837 for dates of service December 2 and 11, 2014. Procedure code 90837 is defined as "Psychotherapy, 60 minutes with patient and/or family member." 28 Texas Administrative Code §134.600(p)(7) requires preauthorization for "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   Review of the submitted information does not support that the services are part of a preauthorized or division exempted return-to-work rehabilitation program. Therefore, the disputed services required preauthorization.

2. The insurance carrier denied disputed services with claim adjustment reason code X170 – "PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600." Submitted documentation does not support that preauthorization was obtained for procedure code 90837 for the dates in question.
3. Because preauthorization was required for the services in question, but documentation does not support that preauthorization was obtained, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	February 18, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.